PLEASE DON'T STAPLE

Corner Drugs, Inc.
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I charge ~~$95~~ (currently discounted to $50) for a complete evaluation. Go ahead and complete these questionnaires and get them back to me, I will give free basic information but I have to charge due to the time it takes to completely evaluate your symptoms. I will promise it will be worth your time and money for me to completely evaluate and explain my recommendations.

MEDICAL HISTORY- MALE ♂

Date: _____

Name _____ Birth Date _____ Age _____

Weight _____lb Weight 1 yr ago _____ Height _____

E-Mail Address : _____

Best phone # to reach you _____

Address _____

Occupation: _____

Education completed: _ Grade school _ High school _ College _ Graduate school

Marital status: ___Single _ Married ___Separated
___Divorced ___Widowed

Spouse/Partner's name: _____

Who lives at home with you?_____

Do you: Smoke? □Yes □No Packs per day _____ # Years smoked _____

Drink Alcohol? □Yes □No Drinks per day _____

Drink cola/coffee? □Yes □No How much per day? _____

How much *pure* water do you drink daily? _____

Do you use artificial sweeteners routinely? □Yes □No If so which ones ? _____

If you don't know the name, what colors are the packets _____
Do you drink diet colas or drinks _____

Do you exercise regularly? □Yes □No How many times per week? _____

Are you currently on a diet or have you been on a diet within the last 2 years? □Yes □ No
What was the name of the diet?
_____

What were your results? _____

List the medications/supplements & OTCs you are now taking or have taken within the last month:
Provide a separate list if needed.

_____

_____

List any allergies you have to drugs, food or other items:

_____

_____

When was your last bowel movement? _____

Do you have a BM at least every day? □Yes □No

Please circle the consistency of your stool
Watery Loose Firm Pellets Soft

Are you allergic to soy? □Yes □No

Are you currently under medical care for any reasons? If yes, please explain:

_____

_____

Have you been diagnosed with erectile dysfunction (ED)? □Yes □No

Do you supplement with testoeterone? □Yes □No

What kind? □Injection or □Topical

Primary Care Physician Name: _____

City & State: _____

Phone (if known): _____

List Operations/procedures you have had:

Operation Performed	Year	Hospital	Doctor/Surgeon

List all times you have been admitted to a hospital overnight (except for childbirth).

Reason Hospitalized	Year	Hospital	Doctor/Surgeon

Please check if any relative (parents, siblings, grandparents, children) have had any of the conditions listed below:

□High blood pressure	□Kidney Disease	□Asthma
□Stroke	□Bleeding Tendencies:	□Tuberculosis
□Cancer	□Seizures	□Colitis
□Emphysema	□Heart Disease	□Anemia
□Ulcers	□Diabetes	□Gout
□Mental Illness		

Indicate how you are related if a family member is:

□Obesity □Extremely Obese

Other Illnesses not listed:_____

To your knowledge were you born □Vaginally or □ C- Section?

Do you take Coumadin/Warfarin/Plavix or Aspirin? □Yes □No

Immunizations current: □Yes □No □ I don't know

Sleep Patterns: Do you go to bed at a regular time most days (6 out of 7)? _____

What time do you go to bed? _____ What time do you wake? _____

Do you sleep through the night? _____

If you awake at night do you fall back to sleep easily? _____

Are you on the computer within 3 hours of time for bed?_____

How do you feel when you first wake up? _____

Do you hit the snooze multiple times? _____

Please explain any sleeping abnormalities _____

Have you had any of the following illnesses:

□Measles	□Diabetes	
□Rubella (German Measles)	□Goiter, Thyroid Disease	
□Malaria	□Bladder or Kidney Infection	□Typhoid
□Chickenpox	□Hives	□Tropical Diseases
□Mumps	□Allergies	□Hepatitis
□Whooping Cough	□Eczema	□Venereal Disease
□Scarlet Fever	□Mono	□Seizures
□Tonsillitis	□Rheumatic Fever	□Meningitis
□Diphtheria	□Poliomyelitis	□Ear Infections
□Asthma	□Pleurisy	□Heart Murmur
□Glaucoma	□Bronchitis	□High Blood Pressure
□Cancer	□Influenza	□Low Blood Pressure
□Angina Pectoris	□Tuberculosis	□Heart Attack
□Ulcer	□Phlebitis	□Kidney Stones

Other illnesses: (Please Explain):

Please list the date and results or comments (if known) of your last:

X-ray:_____

EKG: _____

Blood Count: _____

Date of last examination by a doctor: _____

Please remember over the last 3 days and list everything you have eaten or drank:

_____
_____
_____
_____
_____
_____

How did you hear about Corner Drugs?

_____

If I could wave a magic wand over you, what 3 major symptoms would you like to see disappear?

1._____

2._____

3._____

Please list any additional information that I did not ask that you think I need to know.

Corner Drugs & Compounding Center

PATIENT CHECKLIST FOR SYMPTOMS OF HORMONE IMBALANCE

For Men

Name _____ Date _____

Date of Birth _____email _____ Ph_____

TD

__Low sex drive __Decreased erections __Prostate problems __Decreased urine flow
__Foggy thinking __Memory Loss __Arthritis __Aches/Pains
__Bone Loss __Weight Gain __Fatigue __Decreased stamina
__ Thinning skin __Decreased sense of wellbeing __Sleep disturbances
__Increased urinary urgency __Decreased mental acuity __Decreased muscle mass
__Heart Palpitations __Irritable ___Sagging cheeks/eyelids

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TE

__Oily skin __Aggression __Irritability __Salt/sugar cravings
__Weight gain around the abdomen __Insomnia __Anxiety /7

PD

__Low libido __Prostate problems __Sleep disturbances __Bone Loss
__Aches/Pains __Anxiety/Mood swings __Weight Gain __Headaches
__Water retention __Hair Loss __High estrogen signs /11

PE

__Sleepiness __Mild depression /2

EE

__Prostate problems __Decreased urine flow __Increased urinary urgency
__Weight Gain __Irritable/anxious __Elevated cholesterol /6

ED

__Hot flashes __Night Sweats __Apathy
__Bone Loss __Memory Los __Depressed /6

ThD

__Cold hands/feet __Low Libido __General aches/pains
__Dry Skin __Fatigue (especially evening) __Depression
__Scalp hair loss __Brittle nails __Low Pulse rate/blood pressure
__Memory lapses __Heart palpitations __Constipation
__Low Stamina __Low body temperature __Headaches
__Intolerance to cold __Weight Gain __Anxiety
__Swollen, puffy eyes __Poor concentration __Fibromyalgia
__High cholesterol __Infertility __Dizziness
__Hoarseness __Dull Expression __Tingling/Numbness
__Muscle weakness __Irritable __Word mix-up/slow /31
__Joint pain/aches

ThE

__Weight loss/gain
__Increased Thirst
__Hives/itcing
__Shortness of Breath
__Depression/Irritability
__Emotional swings/aggression
__Shakiness
__Hair Loss
__Chest Pain
__Weakness/fatigue
__Hot clammy skin
__Heat intolerant
__Anemia
__Diarrhea
__Restlessness/Insomnia
__Increased sweating
__Rapid hearbeat
__Decreased Muscle Mass

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CD

__Fatigue (even with rest)
__Chemical sensitivity
__Hives/itching
__Low Blood Sugar
__Sugar craving
__Stress
__Thinning skin
__Confusion
__Allergies
__Aches/pains
__Low Blood Pressure
__Muscle Stiffness
__Sinusitus

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CE

__Sleep disturbances
__Loss of muscle mass
__Stress
__High blood sugar
__Bone loss
__Thinning skin/bruising
__Sugar craving/binging
__Weight gain or loss
__Fatigue
__Anxiety/irritability
__Memory laps
__High triglycerides
__Weight gain waist

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